**Appendix 1A**

Included in this document are comments received by the Exchange during the formal carrier Process Guide comment period. The first column includes the summarized comments submitted by carriers. The second column includes the response and clarifications submitted by the Exchange.

| Comment | Response |
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| *Comment:* One carrier asked if the 834 enrollment audit file and the 834 update file will be combined on the date the audit file is send. | *Response:* The HBE will send two files on the date the audit file is sent. The first will be the daily 834 update file and the second will be the audit file. As described in the comments, the Exchange will expect carriers to process the 834 daily file prior to processing the update file. The files will have a naming convention that will differentiate the files. |
| *Comment:* One carrier asked if there is an enrollment waiting period an individual who was terminated from coverage due to non-payment can be reinstated. | *Response:* For enrollees who have been terminated from coverage due to non-payment, the Exchange will support reinstatement of health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period only if the enrollee has satisfied all payment in arrears through the current period. If the individual is not current on an outstanding payment, the individual will not be eligible for reinstatement of coverage through the Exchange. This means that the applicant is required to pay any outstanding balance from prior coverage periods before reenrolling at a future date. For example, if an enrollee is terminated on 08/01/2014 due to non-payment of premium, to be eligible for Open Enrollment (10/15 - 12/07) the individual must pay any outstanding balance prior to 12/07. If the enrollee has a qualifying event (e.g. birth of a child) they may be eligible to enrollee prior to the Open Enrollment period but must pay any outstanding balance prior to or before reenrolling at a future date.<br><br>Individual balances more than a year old will be forgiven. Some reinstatement eligibility determinations may be processed through a manual review from an internal Exchange team. |
| *Comment:* One carrier asked what an 834 effectuation file is. | *Response:* An effectuation file is a detailed response file generated by the carriers after receiving a transaction file. It includes details about all individuals listed in the transaction file |

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| *Comment*: One carrier asked if premiums will be prorated when a mid-month enrollment or disenrollment occurs. | *Response*: Premiums will be prorated when a mid-month enrollment takes place due to birth, adoption, or death. The prorated premium will be based on the coverage end date and / or coverage begin date. For example, in the case of a mid-month enrollment due to birth, the coverage end date for the previous plan, Plan A, will be the day prior to the birth date of the child. The coverage effective date for the new plan, Plan B, will be the birth date of the child. The prorated premiums will be as follows: Plan A - day of coverage from the 1st of the month until the day prior to the birth date of the child. For Plan B, the prorated amount will be the birth date of the child until the end of the month.<br><br>The detailed transaction format and examples will be discussed during the Technical Meetings with carriers. |
| *Comment*: One carrier asked how premium payments will be sent from the Exchange for families with multiple children | *Response:* The HBE will be aggregating individual payments and payments made on behalf of individuals and sending a monthly payment for all enrollees. |
| *Comment:* Several carriers asked about a unique ID and corresponding details | *Response:* The Exchange will be using a Person ID that uniquely identifies each subscriber and dependent in the Exchange system. The Exchange will send this identifier in the 834 Enrollment file and the 820 Payment file. This identifier will ease reconciliation between the Enrollment and Payment transactions between the Exchange and its trading partners. Person ID will not be communicated by the Exchange to enrollees and should not be communicated outside of the Exchange-Carrier business agreement. |
| *Comment:* Some carriers were interested in how the cost sharing reductions will occur | *Response:* The 834 enrollment file will include details about which cost sharing reduction tier the enrolled individuals are eligible. The reimbursement for cost sharing reductions will come directly from the federal government to the carriers |

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| *Comment*: Some carriers asked questions about how an individual can change their enrollment selection. | *Response:* An individual can only update or re-select their enrollment selection during the Open Enrollment period as long as the current date is not after their coverage effective date (this rule is applicable for Initial Open Enrollment and future Open Enrollments). For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.<br><br>During Open Enrollment, an individual or family can select and re-select a plan until the end of Open Enrollment. The carrier will receive the initial Add enrollment transaction on the day that the individual selects and makes the initial payment for that plan (Plan A). The payment transaction will not be sent until the end of Open Enrollment once the plan selections have been finalized. If the individual or family decides to re-select and enroll in a different plan (Plan B), the Exchange will send a Disenrollment transaction to Plan A, and send an enrollment Add transition to Plan B. Plan A will never receive a payment transaction for the initial Add Enrollment transaction which should minimize the enrollment and payment reconciliation process. |
| *Comment:* Several carriers asked the sequence of initial enrollment and payment transactions | *Response:* During initial enrollment, the Exchange will not send an enrollment transaction if the individual has not initiated payment. The initial payment must be submitted by the individual prior to confirmation of enrollment through the Exchange. However in the case that the initial payment is invalid, for example due to non sufficient funds, the Exchange will send the Enrollment transaction through the daily 834 file and if the error is not corrected by the coverage start date, the Exchange will send a disenrollment transaction through the daily 834 on or around the 1st of the month. The individual will have an Enrollment history of 'Cancelled' in the Exchange which indicates that their enrollment was never active. |
| *Comment:* One carrier asked if communication preferences collected on the application will be sent to the carriers | *Response:* In general, the preferences of the individual as captured through the application, including language preference or communication preferences, is specific to the Exchange and will not be required for the carriers to support. Other elements that are captured during the application process and that are also fields within the segments of the 834 or 820 file, including relationship to subscriber, will be passed on to the carrier. |

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| *Comment:* One carrier asked about how far retro disenrollment can occur. | *Response:* Per the final regulations, individuals have 30 days to report a changes to the Exchange, however the Exchange is required to retro enroll or disenroll 60 day from the event for birth, adoption or death. These are the only Special Enrollment qualifying events that require a retro enrollment or disenrollment, except in the instance of extreme extenuating circumstances. Other qualifying events do not require a retro enrollment or disenrollment and generally, coverage will begin on the 1st of the month following the reported event. |
| *Comment:* There were several comments about reinstatements | *Response:* For enrollees who have been terminated from coverage due to non-payment of premium, the Exchange will support reinstatement of health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period only if the enrollee has satisfied all payment in arrears through the current period. If the individual is not current on an outstanding payment, the individual will not be eligible for reinstatement of coverage through the Exchange. This means that the applicant is required to pay any outstanding balance from prior coverage periods before reenrolling at a future date. For example, if an enrollee is terminated on 08/01/2014 due to non-payment of premium, to be eligible for Open Enrollment (10/15 - 12/07) the individual must pay any outstanding balance prior to 12/07. If the enrollee has a qualifying event (e.g. birth of a child) they may be eligible to enrollee prior to the Open Enrollment period but must pay any outstanding balance prior to before reenrolling at a future date.<br><br>The Exchange will not limit how many times an individual can reinstate in a QHP for during a calendar year due to the potential churn between Medicaid eligibility and subsidized or non-subsidized coverage through a QHP. There are many business scenarios for re-enrollment, or reinstatement with a break in QHP coverage, including a change in eligibility to or from Medicaid. In all cases, the Exchange will support reinstatement of health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period only if the enrollee has satisfied all payment in arrears through the current period. |

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| *Comment:* One carrier asked about the reconciliation process | *Response:* The Exchange will report the Enrollment and Payment Transaction through the monthly Audit files. If discrepancies exist between the Exchange file and the carrier system, the carrier is expected to internally work any discrepancies, and report any unresolved discrepancies to the Exchange. Depending on volume estimates, the Exchange will require a carrier to report discrepancies manually through a call to the Exchange account worker or through a consolidated list or report sent to an Exchange account worker.<br><br>Reconciliation between the Exchange and carriers is a manual process.<br><br>The Exchange will publish an 834 and 820 schedule for the 2014 year which provides the dates that the carrier can expect monthly 834 and 820 Audit files. |
| *Comment*: One carrier asked if carriers will have access to the HBE "system of record" to reconcile differences. | *Response:* Carriers will not have access to the Washington Health Benefit Exchange system for Enrollment or Payment records. The Exchange will report the Enrollment and Payment Transaction through the monthly Audit files. If discrepancies exist between the Exchange file and the Carrier system, the Carrier is expected to report these differences to the Exchange. Depending on volume estimates, the Exchange will require a Carrier to report discrepancies manually through a call to the Exchange account worker or through a consolidated list or report sent to an Exchange account worker. |
| *Comment:* One carrier asked if the Exchange could link the individual directly to the carrier website following plan selection and payment to allow an individual to select a primary care provider and get connected to electronic resources available from carriers | *Response:* This is a feature the Exchange may explore for future versions of the Exchange. Due to the condensed timeframe articulated by the Affordable Care Act, the Exchange will not be able to include this feature in version 1.0. |
| *Comment*: One carrier asked if the HBE will include a reason code for special events. | *Response:* This is a data element the Exchange would like to transmit if the final layout of the 834 file allows. This will be communicated in future guidance if the Exchange is able to transmit this code to carriers. |

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| *Comment:* One carrier asked why there is a gap between the enrollment file and the payment file. | *Response:* The payment cutoff date is the 23rd of each month. The Exchange will process the payments for 5 business days before creating the 820 payment reconciliation file and the actual ACH payment. The ACH payment is processed through Key Bank. The Exchange continues to work with Key Bank to ensure that funds have cl+H27eared before sending them to the Issuers. If a payment from an individual reverses (for example it is NSF) before the 5 business days then it will not be included in the monthly 820 and corresponding payment but it will show in the daily 820 and payment. |
| *Comment*: One carrier asked if the Exchange will send partial payment. | *Response:* The Exchange will only send full payment. |
| *Comment*: One carrier asked if for 'clean up' payments made by individuals during the grace period will the Exchange send an 820 and the corresponding payment. | *Response:* If an individual makes a premium payment during their eligibility for a grace period, the Exchange will send the carrier both an 820 file and the corresponding payment daily after the 5 business day settlement process. |
| *Comment:* One carrier noted that their preference is that the HBE manage the delinquency process | *Response:* The HBE will monitor and manage delinquent payments and will not notify carriers when the delinquency notice is sent to an individual or family. The intention of including the billing calendar was to increase carrier's visibility into the Exchange business processes. The Exchange understands that carriers will pend claims if a payment is missed until payment is received or a termination transaction is received from the Exchange.<br><br>If an enrollee has missed a payment and exhausted their grace period, the Exchange will send a Disenrollment transaction to the carrier on the 1st of the month after the grace period. |
| *Comment:* One carrier noted their preference to send the certificate of creditable coverage | *Response:* The HBE is working with HHS to determine the value in sending the certificate of creditable coverage in 2014 and beyond. The certificate of creditable coverage may not be needed when there are no preexisting conditions and guaranteed issue for health insurance coverage. |

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| *Comment:* One carrier asked if there are any transmissions either way between Key Bank, the Exchange's banking business partner, and the carriers. | *Response:* The Exchange has selected Key Bank as their banking business partner. Key Bank will send premium payments to carriers on behalf of the Exchange using ACH transactions. The document number will be used to match ACH payment to the 820 transaction file. |
| *Comment:* One carrier asked if there will be a cutoff time on the 23rd of the month for coverage effective the 1st of the following month. | *Response:* The cut off time for individuals enrolling or making updates on the 23rd is dependent on the Exchange batch scheduling which has not been finalized. With that said, the current vision is that if the member applies on the 23rd of the month to be effective 1st of the following month the individual must complete Plan selection and initial payment before 11:59pm. This cutoff period is dependent on the fact that the Enrollment batch to collect all adds, updates, and deletes will run after midnight, on the morning of the 24th. |
| *Comment:* One carrier asked what "There will be an 834 file for each health plan" means. | *Response:* The Exchange will send a separate 834 file for each QHP in the Individual and Family market and SHOP market. For example, if a carrier offers 6 QHPs through the Exchange for the Individual and Family market and 4 QHPs for the SHOP markets, that carrier will receive a total of ten 834 files. The Exchange will not send files per Metal Level, for example Platinum, Gold, Silver, etc. |
| *Comment:* One carrier asked if Exchange members are allowed to have dual coverage | *Response:* Individuals will only be allowed to be enrolled in one QHP at a time. Furthermore, one of the eligibility requirements for those receiving advance premium tax credits is that the individual does not have access to other minimum essential coverage. There will, however, be instances where an individual is enrolled in Medicaid and a QHP for a limited duration. This will occur when there is a change of circumstance that moves an individual to Medicaid from an existing APTC enrollment. |
| *Comment:* One carrier asked if carriers will receive a daily 820 file. | *Response:* The Exchange will produce the daily 820 file but carriers may choose to process them on a different schedule. |
| *Comment:* A question was raised about if a carrier would be required to send refunds to HBE or HHS. | *Response:* The HBE will not require carriers to send refunds, except in isolated circumstances. In the situation where an individual is retroactively disenrolled, the HBE will short the next payment and detail the removal in the 820 payment transaction.<br>The reconciliation process for APTC and CSRs has not been released by HHS and the HBE does not have details about how carriers will reconcile payments with the federal government. |

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| *Comment*: One carrier asked if the carriers will receive a copy of the information sent to HHS for the tax credit. | *Response:* The 834 Enrollment file will include information about the amount of tax credit to expect from the federal government to make the carrier whole. |
| *Comment:* One carrier asked what format will they send discrepancies to the Exchange | *Response:* The Exchange will report the Enrollment and Payment Transaction through the monthly Audit files. If discrepancies exist between the Exchange file and the carrier system, the carrier is expected to internally work any discrepancies, and report any unresolved discrepancies to the Exchange. Depending on volume estimates, the Exchange will require a carrier to report discrepancies manually through a call to the Exchange account worker or through a consolidated list or report sent to an Exchange account worker.<br><br>Reconciliation between the Exchange and carriers in a manual process. The specific format is still to be determined. |
| *Comment:* One carrier asked for clarification on the partial payment and delinquency process. | *Response*: The Exchange will not accept partial payments. If partial payments are received by the Exchange, Exchange accounting staff will work with enrollees to collect the full payment prior to sending payment transactions to the carrier. The Exchange will only send full payments to the carriers. |
| *Comment:* One carrier asked for clarification on how the Exchange will prorate premiums. | *Response:* Premiums will be prorated when a mid-month enrollment takes place due to birth, adoption, or death. The prorated premium will be based on the coverage end date and / or coverage begin date. For example, in the case of a mid-month enrollment due to birth, the coverage end date for the previous plan, Plan A, will be the day prior to the birth date of the child. The coverage effective date for the new plan, Plan B, will be the birth date of the child. The prorated premiums will be as follows: Plan A - day of coverage from the 1st of the month until the day prior to the birth date of the child. For Plan B, the prorated amount will be the birth date of the child until the end of the month. |

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| *Comment:* One carrier asked when should the Qualified Health Plan expect to receive the first 834 Enrollment file. | *Response:* The carriers can expect to receive the first enrollment Update file on October 1st, 2013. The first full Audit file with be sent on October 24th, 2013.<br><br>For annual Open Enrollment period begins October 15 through December 7 with benefit years beginning on or after January 1, 2015, the first enrollment Update file will be sent on October 15th.<br><br>In additional, the first 820 payment file will be sent to Issuers 5 business days after the December 23rd enrollment cutoff. For annual Open Enrollment, the 820 payment file will be sent to Issuers 5 business days after the December 7th enrollment cutoff. |
| *Comment:* One carrier asked if there is a process to verify eligibility outside of the 834 Enrollment files | *Response:* Carriers can contact the Exchange if discrepancies occur regarding eligibility or enrollment. This will be a manual process. |

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| *Comment:* One carrier asked what information will the Exchange send to the individual, and what will be required for the QHP to send. | *Response*: Below is a list of enrollee correspondence that the Exchange will be responsible for sending:<br>• Eligibility Decision for Health Care Coverage notice: The Exchange will send individuals an eligibility determination notice that specifies what programs the primary applicant and the other members of the household are eligible for including Medicaid, Apple Health for Kids, APTC, or QHP.<br>• Upcoming Open Enrollment Deadline notice: During Open Enrollment the enrollee will receive an Upcoming Open Enrollment Deadline notice which states the beginning and end date for Open Enrollment and prompts the enrollee to select and enroll in a Plan for the next coverage period.<br>• Upcoming Special Enrollment Deadline notice: If an enrollee is eligible for a Special Enrollment Period and has not selected a plan, the Exchange will send the enrollee an Upcoming Special Enrollment Deadline notice to prompt them to return to the Exchange to select and enroll in a plan. This notice also explains to the enrollee that if they do not update their plan selection they may be disenrolled from coverage.<br>• Health Benefit Termination notice: In a disenrollment scenario, the Exchange will send the enrollee a Health Benefit Termination notice which states the day that their coverage in an Exchange QHP will end.<br>• Yearly Advance Premium Tax Credit Summary notice: The Exchange will provide enrollees who are eligible for APTC a yearly notice that summarizes the amount of APTC they received for the previous tax year.<br>• Monthly Invoice: The Exchange will invoice enrollees in the individual market on the 1st of the month prior to the month of coverage.<br>• Receipt of Payment: The Exchange will generate a receipt of payment for individuals when enrollees make a premium payment through the Exchange.<br>• Premium Payment Delinquency notice: The Exchange will send a delinquency notice to the enrollee on the 1st of the month following a missed payment. |
| *Comment*: One carrier asked if the first initial payment fails to clear for the enrollee, when would the enrollee be termed and when would the QHP expect to receive the termination record on the 834 Enrollment file | *Response:* In the case that enrollee's initial payment fails, the enrollees Enrollment status will be updated to "Cancelled' on the last day of the month before their coverage begin date. The enrollee will have a record of their Enrollment action but it will be associated with a 'Cancelled' status and will never have been updated to 'Active'. The Exchange will send a disenrollment transaction to the QHP through the daily 834 on or near the 1st of the month following the failed payment. |

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| *Comment:* One carrier asked how prorated premium will be calculated. | *Response:* Premiums will be prorated when a mid-month enrollment takes place due to birth, adoption, or death. The prorated premium will be based on the coverage end date and / or coverage begin date. For example, in the case of a mid-month enrollment due to birth, the coverage end date for the previous plan, Plan A, will be the day prior to the birth date of the child. The coverage effective date for the new plan, Plan B, will be the birth date of the child. The prorated premiums will be as follows: Plan A - day of coverage from the 1st of the month until the day prior to the birth date of the child. For Plan B, the prorated amount will be the birth date of the child until the end of the month. |
| *Comment:* One carrier shared a preference for an indicator on the 834 Enrollment file when the enrollee is in the grace period. | *Response:* The 834 Enrollment file will not have a field to indicate payment status. The carriers' reconciliation process will determine when an individual is delinquency on payment.<br><br>The detailed transaction format and examples will be discussed during the Technical Meetings with carriers. |
| *Comment:* There were several comments about the grace period and delinquency process | *Response:* For subsidized enrollees, the QHP will be expected to pay claims during the first month of a grace period, but may suspend claims in the second and third months. The QHP cannot deny claims during the second and third months of the grace period. If the individual settles all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third months could be denied. QHP issuers must notify providers who submit claims that an enrollee is in the second or third month of the grace period and that a claim may be denied if the outstanding premiums are not paid in full.<br><br>The Exchange has received and will consider the feedback to clearly state in the Delinquency Notice to the enrollee that claims can be resubmitted to the QHP once the premium is received. |

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| *Comment:* One carrier asked that if the QHP is notified of the death of an enrollee, can the QHP term the enrollee before the termination record is received on the 834 Enrollment file. | *Response:* If the QHP is notified of the death of an enrollee, the QHP cannot terminate the enrollee coverage before the termination record is received on the 834 Enrollment file. The QHP can reach out the Exchange to notify them of the reported death and the Exchange may contact the family. Due to the fact that a reported death may impact a family's eligibility determination, the death must be reported to the Exchange prior to updating or impacting an enrollee's coverage. For Example, in a household reports a date of death for an enrollee currently in their household; this change may impact both their household composition and previously reported income. Changes to both household composition and previously reported income may change the household program eligibility to Medicaid, subsidize or non-subsidize coverage. This change in program eligibility may make the household eligible for a Special Enrollment period. |
| *Comment:* One carrier asked if the Exchange will accept advance or pre-payments of premiums for future months and if so, will these be passed on to the QHP. | *Response:* Overpayments will be accepted by the Exchange and be applied to future invoices. The Exchange will retain the funds and remit payments to the Issuers monthly. |
| *Comment:* One carrier asked if in the case that an individual sent payment directly to the carrier, is there an opportunity for the QHP to send the payment to the Health Benefit Exchange for processing | *Response:* If the Issuer receives a payment directly, then it is expected that the Issuer will process the payment and send notification of the payment to the Exchange via an 820 file. The Exchange will send acknowledgements for 820 files sent to them in the form of a 999. When payment notifications are received by the Exchange, the enroll records will be updated and normal enrollment activities and notifications will occur. |
| *Comment:* One carrier asked when should the Qualified Health Plan expect to receive the first 820 Premium file. | *Response:* The first payment file will be sent to Issuers 5 business days after the December 23rd cutoff. |

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| *Comment:* One carrier asked is an enrollee contact the carrier directly with a request to terminate coverage. | *Response:* Termination of coverage must be reported to the Exchange.<br><br>The QHP cannot terminate the enrollee's coverage before the disenrollment record is received on the 834 Enrollment file. The QHP can reach out the Exchange to notify them of the reported termination request and the Exchange may contact the enrollee. Due to the fact that an individual's termination in coverage may impact a family's eligibility determination, a request for termination of coverage must be reported to the Exchange prior to updating or impacting an enrollee's coverage. For Example, in a household reports a request for termination of coverage for an enrollee currently in their household, this change may impact both their household composition and previously reported income. Changes to both household composition and previously reported income may change the household program eligibility to Medicaid, subsidize or non-subsidize coverage. This change in program eligibility may make the household eligible for a Special Enrollment period. |
| *Comment:* One carrier asked for clarification on the use of the term ' reinstatement'. | *Response:* The previous reference to reinstatement has been corrected to reenrollment and more accurately describes the Exchange's business process. Reenrollment refers to any situation when an enrollee is disenrolled and reenrolled again. This may result in a gap in coverage for the enrollee. |
| *Comment:* There were some comments about the eligibility process and conditional eligibility | *Response*: The updated process guide provides additional detail about the eligibility process and how it will affect the enrollment process. Please see section 3.4 for addition detail. |
| *Comment*: There were several comments about what the correspondences and invoices the Exchange will send. | *Response:* Per these comments, the Exchange has added a new section to the Final Enrollment and Billing Process Guide which include drafts of the correspondences and invoices. |
| *Comment:* One carrier asked for clarification on the reinstatement process. | *Response:* The previous reference to reinstatement has been corrected to reenrollment and more accurately describes the Exchange's business process. Reenrollment refers to any situation when an enrollee is disenrolled and reenrolled again. This may result in a gap in coverage for the enrollee. |

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| *Comment*: One carrier asked for clarification on the rules for delinquent payments. | *Response:* The Exchange grants non-subsidized enrollees in the individual market a 30 day grace period beginning on the 1st of the month following a missed payment. The Exchange will send a Delinquency Notice to the enrollee on the 1st of the month following a missed payment. If the 30 day grace period for unsubsidized individuals has been exhausted, the last day of coverage will be the last day of the month prior to the 30 day grace period. A grace period can only be applied to enrollees who are current on their past month's premium payment and the Exchange will not allow consecutive or rolling grace periods.<br><br>The Exchange grants subsidized enrollees in the individual market a 90 day grace period beginning on the 1st of the month following a missed payment. The Exchange will send a Delinquency Notice to the enrollee on the 1st of the month following a missed payment. If the 90 day grace period for individuals receiving advance payment of the premium tax credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period. The QHP will be expected to pay claims during the first month of a grace period, but may suspend claims in the second and third months. |
| *Comment:* One carrier asked if the Exchange is determining eligibility for Special Enrollment prior to sending enrollment to the carrier. | *Response*: The Exchange will monitor and manage special enrollment rules and will only send an enrollment transaction to the QHP once the individual or family has been determined eligible for a special enrollment period, and has selected a plan. Furthermore, if the individual or family changes plans during a special enrollment period, the Exchange will send the corresponding disenrollment transaction to the previous Plan. |
| *Comment:* One carrier asked about how the HBE will accommodate disabled dependents and newborns | *Response:* The Exchange will allow individuals to enroll in a QHP regardless of their disability status. If an individual comes to the Exchange and is seeking services offered by Medicaid, through their long-term care or SSI related Medicaid programs, the Exchange will make every effort to get the individuals to the appropriate place to seek coverage.<br><br>carriers will be expected to continue to comply with state law, including RCW 48.43.115 ("The Erin Act") |
| *Comment:* One carrier asked for clarification on the retroactive disenrollment dates. | *Response*: The Process Guide has been reviewed and updated to reflect the feedback in this comment. The Exchange will support mid-month terminations in the case of death. The effective end date of coverage will be the reported date of death. |

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| *Comment*: One carrier asked how the Exchange will communicate delinquency to the carrier. | *Response*: The 834 Enrollment file will not have a field to indicate payment status. The carriers' reconciliation process will determine when an individual is delinquency on payment.<br><br>The detailed transaction format and examples will be discussed during the Technical Meetings with carriers. |
| *Comment:* One carrier asked how carriers will differentiate subsidized from non-subsidized individuals. | *Response:* The Exchange system will monitor and manage delinquency rules for both the unsubsidized and subsidized population. In the case that an individual is delinquent on payment and does not make a payment on their outstanding premium by the end of the grace period, the Exchange will send a disenrollment transaction to the QHP through the daily 834 Update file.<br><br>If a subscriber is eligible for APTC, the 834 Enrollment file will include an APTC segment. The 820 will not include a unique segment for APTC eligible individuals. The detailed transaction format and examples will be discussed during the Technical Meetings with carriers. |
| *Comment:* One carrier shared a concern with the expectation that carriers are required to send an 820 file to the exchange to report any premium payments made from the individual to the carrier. | *Response*: If the carrier receives a payment directly, then it is expected that the carrier will process the payment and send notification of the payment to the Exchange via an 820 file. The Exchange will send acknowledgements for 820 files sent to them in the form of a 999. When payment notifications are received by the Exchange, the enrollee records will be updated and normal enrollment activities and notifications will occur. |
| *Comment:* One carrier asked for clarification on the payment and reconciliation process. | *Response:* Individuals can make payment through the Exchange from the 1st to the 23rd of each month. Payments are processed by the Exchange and an 820 remittance detail file is produced. The 820 file is placed in a directory for the Issuer so it can be pulled via SFTP and processed by the Issuer. In addition to the 820 file, the Exchange makes an ACH payment to the Issuer via Key Bank. Reconciliation can be performed by the Issuer by comparing the 834 enrollment audit file and the 820 remittance detail file. If a payment is received late, it will be processed and remitted daily using the same approach. The detail process flows for this will be documented and presented at the scheduled Exchange technical meetings in November. |

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| *Comment*: One carrier asked if the APTC subsidy payments will be sent to the carriers from HHS | *Response:* The US Department of Health and Human Services will coordinate payments of the advance premium tax credits and cost sharing reductions directly with the carriers. |
| *Comment*: One carrier asked about the frequency of the payment file. | *Response*: Individuals can make payment via the Exchange from the 1st to the 23rd of each month. Payments are processed by the Exchange and an 820 remittance detail file is produced. The 820 file is placed in a directory for the Issuer so it can be pulled via SFTP and processed by the Issuer. In addition to the 820 file, the Exchange makes an ACH payment to the Issuer via Key Bank. Reconciliation can be performed by the Issuer by comparing the 834 enrollment audit file and the 820 remittance detail file. If a payment is received late, it will be processed and remitted daily using the same approach. The detail process flows for this will be documented and presented at the scheduled Exchange technical meetings in November. |
| *Comment:* One carrier shared a concern that subsidized payment information will not be sent frequently enough. | *Response:* It is the Exchange's understanding from HHS that the advance payment of tax credits will only occur once per month. The Exchange anticipates additional guidance from HHS on the frequency and format of APTC payment. |
| *Comment:* One carrier asked for clarification on the process for termination due to death. | *Response*: The Exchange will support mid-month terminations in the case of death. The effective end date of coverage will be the reported date of death. If the subscriber or any other dependent in the household is termed for death, the remaining household members will be eligible for a special enrollment and have the option to re-enrolled under a new policy.<br><br>The detailed transaction format and coverage end date examples will be discussed during the Technical Meetings with carriers. |
| *Comment:* One carrier asked for clarification on the delinquency process as it applies to notices and section §156.270 Termination of coverage for qualified individuals in the final rules. | *Response:* The Exchange intends to send a termination of coverage notice that complies with the requirements of 45 CFR § 156.270 on the issuers behalf. The Exchange is working with CMS to clarify the requirement outlined in § 156.270 that states if an enrollee's coverage in a QHP is terminated for any reason, the QHP must provide the enrollee with a notice of termination of coverage. |

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| Comment: | *Response*: The Exchange will send Termination transactions in the daily 834 Update file. This means that the carrier will always receive an explicit Delete transaction when an enrollee is terminated. The 834 Audit file will only include active enrollments; therefore, terminated enrollees will never be sent through the Audit file and means that a record will not exist on the Audit File. |
| *Comment:* One carrier asked about Medicaid enrollments and the process for how enroll files will be generated. | *Response:* Eligibility for Medicaid and CHIP will be determined in the Exchange system, the enrollment process will be defined by the state. The Medicaid enrollment files will continue to be generated by Provider One. |
| *Comment:* One carrier asked for clarification on the coverage start date for an individual who is eligible for Special Enrollment. | *Response:* Unlike during Open Enrollment, during the Special Enrollment period once an individual or family selects and enrolls in a QHP they cannot change their enrollment. If an individual makes an enrollment decision and initiates payment for the plan they will be effectually enrolled based on the coverage start date that has been defined per Section 4, Special Enrollment. |
| *Comment:* One carrier asked for clarification on the process for payment received by the carrier. | *Response:* As required by the ACA, the Exchange must permit individual to pay the carrier directly. Therefore, the carrier-to-Exchange 820 is required to capture receipt of the payment. |
| *Comment*: One carrier asked about the rules for reporting a change of circumstance and on the special enrollment period. | *Response:* Per the final regulations, the Exchange must require an enrollee to report any change with<br>respect to the eligibility within 30 days of such change. Furthermore, a<br>qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP. |